JPB Projects 2016/17 Provincial Report Analysis

April 2018

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JPB Projects 2016/17 Provincial Report Analysis

Executive Summary

A total of twenty-seven JPB projects have been approved, with twenty-six spread across the five regions, and one project that is provincial in scope implemented by the Provincial Health Services Authority. This report synthesizes findings from annual reports submitted by projects for the 2016-17 fiscal year.

About the projects

Each of the projects differs in clinical focus, types of health professionals, and operates and organizes their services in different ways. The most common clinical focus is primary care and/or mental health & substance use (71% of projects). Navigation, chronic disease & home care and maternal care were the clinical focus of the remaining projects.

Clinical focus	Number of projects
Primary Care	7 (26%)
Mental Health and Substance Use	8 (30%)
Primary Care & Mental Health	4 (15%)
Chronic disease & home care	2 (7%)
Maternal care	1 (4%)

Service Delivery Model	Number of projects
Distributed model	4 (15%)
Clinic based with outreach	4 (15%)
Distributed model with centralizing element	3 (11%)
Clinic based	3 (11%)
Navigator	3 (11%)
Mixed	5 (19%)
Unknown	3 (11%)
Mobile team	2 (7%)

"The focus of the [care team] is on enhancing the strengths of Indigenous patients/families while supporting self-determination."

Project service models were grouped into the following categories.

- A **distributed model** was reported by 15% of projects, in which providers work in multiple locations. This model increases geographical coverage of services available.
- **Clinic-based models** with outreach services (reported by 15% of projects) or without outreach services (reported by 11% of projects) focused on delivering care out of a single physical location and all focused on primary care. Being housed within community was a key part of the success mentioned by many projects.
- A **distributed model with centralizing elements** was reported by 11% of projects. These projects are similar to the distributed model in that their team members are made up of clinicians working in different locations, but differ in that there is a centralizing element, a staff person or a common set of tools or processes that support the team in integrating and coordinating care.

> "Wisdom, with the focus on medicine, culture, tradition and language, is addressed through supporting connections with elders and cultural knowledge keepers."

- **Navigator** models were reported by 11% projects. These projects focus on providing support to remove access barriers, support cultural safety, health literary and smooth transitions in care for clients.
- Two projects are **outreach/mobile teams** that focus on bringing teams of professionals to individuals and communities, either on an ad-hoc basis or on a set schedule. Both of these projects focused on mental health and substance use.
- A further 22% of projects were deemed to include a mixture of the above described models.

All projects reported delivering services to Status First Nations. Nearly all projects (91%) reported serving Métis, Inuit and non-Status First Nations as well. Nearly half of projects reported providing services to the general public (48%) and over half reported delivering care away-from-home/off-reserve (60%).

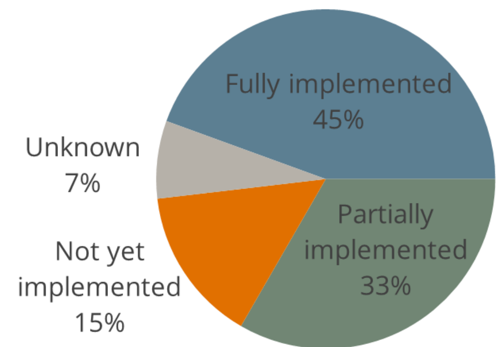
The number of client visits has increased by 1.5 times from 2016/17 to 2015/16 from 17,635 to 25,682.

Each project leveraged resources from partner agencies in unique ways. Clinician salaries, clinician benefits, travel funds, supplies and equipment, physical infrastructure, IT hardware and software, MOA support and clinical supervision were covered by a myriad of arrangements with local host communities, health authority partners, JPB or other funding streams.

REGION	# Client visits 2015/16		# Client visits 2016/17
All Regions	17,635	X 1.5	25,682
Fraser	10,878	X 1.3	14,576
Interior	5,755	X 1.5	8,502
Northern			310
Vancouver Coastal	193	X 2.7	524
Vancouver Island	809	X 2.2	1,770
Provincial Project			15

45% of projects are fully implemented

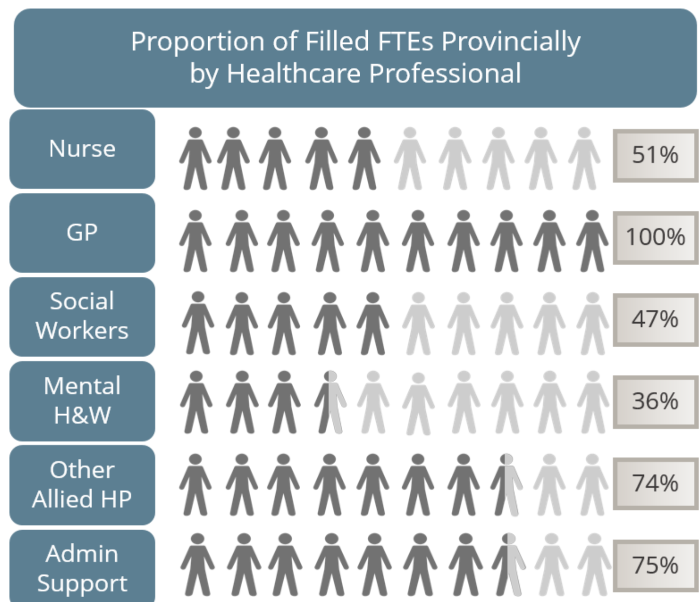
Based on the 2016/17 annual narrative report 45% (12) of projects are fully implemented (all clinicians on the team hired and seeing patients), 5% (4) are not yet operational (no clinicians hired and no patients being seen) and 37% (10) are partially operationally (some clinicians hired and seeing patients, but not the entire project team). There is insufficient information in the reports to classify the stage of implementation for two projects (7%).



Recruitment and retention continues to be an ongoing challenge for the projects.

As of July 2017, 53% (59 out of 111) JPB-funded FTEs were filled across the province. Of the positions that were yet unfilled, 26% had not yet been posted, 11% were in the recruitment phase, and 21% had turned over and not yet been re-hired.

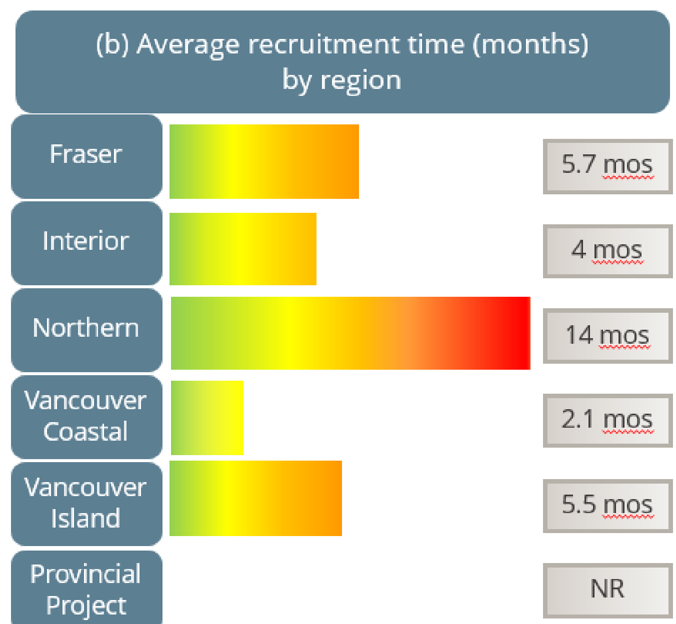
Mental health and wellness professionals were the most difficult to recruit, with only 36% of eligible positions filled and a 5 ½ month average recruitment time across the province.



Social workers were the second most difficult position to fill (47% of eligible positions filled and a 6 ½ month average recruitment time) followed by nurses (51% of eligible positions filled and a 10 month average recruitment period). All physician positions were reported to be filled. The Northern region experiences the highest average recruitment time of 14 months, with Vancouver Coastal experiencing the lowest at 2 months.

Supports that are working well

Processes, tools and resources that are facilitating collaboration and integration of care included:



- Clarity on service model, client population and roles and responsibilities.
- Technology and/or client record management:
  - **65% of projects reported using an EMR.** An additional three projects were in the midst of obtaining an EMR and three projects mentioned the desire to gain access. The ability of an EMR to interact with other clinical systems, or the presence of more than one clinical system, was also raised as a facilitator.
- The development of clinical policies and procedures.
- Management and admin support:
  - Need for administrative and management support of new project teams.
- Communication and relationship development.
  - Capitalize on existing relationships and partnerships and the benefits of investing time in building and maintaining partnerships.

The top implementation challenges experienced by projects were IT issues, lack of physical and confidential office space and recruitment of healthcare staff

Other implementation issues included the complexity and length of project implementation tasks and rollout of project funding. Recruitment challenges included a lack of trained candidates and an inability to attract qualified candidates relating to a lack of local housing for providers or union & seniority issues.

Other staffing challenges included retention & burnout and the amount of management time being dedicated to human resource functions.

Projects are employing strategies to circumvent these challenges, including contracting out services, splitting funded positions across more than one provider, supporting initiatives to encourage First Nations youth to pursue health careers and re-profiling positions to another health care provider available locally that will still meet the needs of the community.

Retention and burnout are being addressed by projects through developing support systems for Indigenous staff. Others are developing clinical processes to manage caseloads, supporting comprehensive professional education opportunities or nurturing collaborative teams that enable clinicians to ensure the non-medical needs of clients are met.

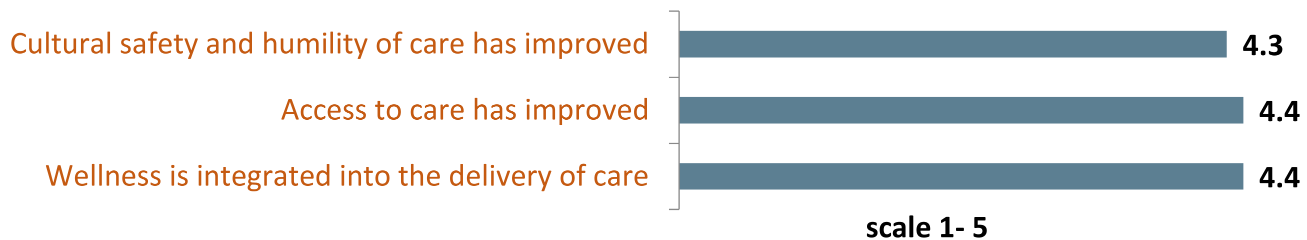
Barriers to Access

Access issue	Mitigation strategy
Fragmentation of service	• Navigators providing continuity of care • Projects integrating within wider health care system: developing clinical policies and procedures relating to referrals, attending hospital rounds, developing relationships with partners, implementing EMRs and addressing interoperability
Service availability	• Hiring staff of greatest need and availability locally • Actively recruiting providers and addressing recruitment issues • Addressing financial barriers by arranging transportation, elimination of fees • Basing clinics in-community • Having clinicians travel into community
Flexibility of services	• Providing home visits or delivering care in a location of the client's choosing • Reserving a number of appointments for faster access to JPB program referrals • Having extended hours
Interpersonal quality of care	• Alternative remuneration models that support physicians to spend more time with patients
Cultural safety & trust	• Working with Elders and cultural knowledge keepers, learning and respecting protocols and promoting traditional methods of personal wellness • Training team members in cultural safety • All of the regions have at least one self-identified indigenous staff member working within projects, many regions reporting that up to 50% of staff self-identify as Aboriginal • Providing discreet and confidential services (providing services at home or offices in town).

85% of projects reported that they strongly agree or agree that cultural safety and humility within care has improved as a result of the project.

95% of projects strongly agreed or agreed that as a result of the project wellness is integrated into the delivery of care and 80% of projects strongly agreed or agreed that access to care has improved as a result of the project.

"The most significant challenge has been to recruit qualified and appropriate candidates who are a good fit and understand working in a First Nations context in a culturally safe and respectful manner".



Sustainability

Projects reported that financial sustainability, administrative and clinical supports, client load and provider burnout are the key sustainability issues.

Recommendations:

- Detailed analyses of the provincial-level factors and supports that could aid in recruitment of nurses, mental health & wellness professionals and social workers.
- Investigate and support opportunities for projects to learn from each other and share tools and strategies. Consider the development of a Primary Care integration 101 tool for communities.
- More analysis of EMR implementation and interoperability issues.
- Consider additional requests for supports and assistance by individual projects, including ongoing management and administrative supports, investing in solutions for communities identifying provider housing as a barrier, projects requesting FNHA's assistance in managing partnership issues.

Our thanks

The stories from projects are heartwarming and inspiring. Many different individuals and organizations throughout the province are systematically addressing barriers and filling gaps in health services through partnerships, creativity, problem solving and resilience.

We raise our hands to you. Thank you for your hard work and dedication.

"We provide medical services that are open to the public in addition to our status Clients. This is an opportunity to bridge the gaps between First Nations only clinics and the general public showcasing the level of service we provide"

Section 1: Background

1.1 About Joint Project Board

The Joint Project Board (JPB) was established in 2012 and is a senior bilateral forum between the Assistant Deputy Ministers of the BC Ministry of Health, and the First Nation Health Authority's (FNHA) Chief Operating Officer and its Vice Presidents.

Effective July 2, 2013, Health Canada transferred the funds it had historically used to pay Medical Services Plan (MSP) premiums on behalf of First Nations residents in BC to the FNHA. A portion of these funds were set aside by the FNHA to support JPB projects and initiatives related to MSP services.

A key focus of the JPB is to enhance services and delivery through:

- Advancing strategic priorities;
- Overcoming policy barriers;
- Supporting priorities and initiatives of the regions; and,
- Supporting integration of services and initiatives of the province and FNHA.

The JPB projects must improve one or more of the following for First Nations people:

- Improve *access* to health services;
- Increase service delivery by *regulated health professionals;*
- Increase *sustainability*[1] of services;
- Be *collaborative* and *innovative*; and
- Support regional priorities.

JPB projects must provide direct service delivery to First Nations people in one of the following areas: primary care, mental wellness and substance use, maternal and child health and oral health services.

A total of 27 projects were funded across the province. Five projects (one per region) have additionally been selected through regional processes to serve as prototype projects. These projects will receive additional resources to support their implementation and in-depth project evaluations.

[1] The investment enables continuous service delivery over time.

1.2 About the Joint Project Board Evaluation

The approach to evaluating JPB projects has evolved over time. The evaluation approach has been adapted to balance high-level data collection from all JPB projects to gauge overall trends, successes and lessons learned, while enabling a comprehensive evaluation of a subset of projects.

Finding this balance has led to the development of a streamed approach to the JPB Projects Evaluation consisting of:

1) A provincial analysis utilizing the JPB Project Annual Report for all 27 projects (Provincial Analysis) and prototype evaluation data – this report is fulfilling this evaluation component for 2016/17. Similar reports will be completed for 2017/18 and 2018/19.
2) A focused exploration of facilitators and constraints to full implementation of five prototype projects (Prototype Project Gap Analysis and Process Evaluation); and
3) Full in-depth evaluations of the five prototype projects to assess Project outcomes.

The purpose of the JPB Projects Provincial Analysis stream of the JPB evaluation is to:

- Identify models and supports that are working well;
- Identify implementation issues that the JPB is in a position to address;
- Share innovations or lessons learned across other JPB Projects; and
- Measure outcomes across projects such as access to culturally safe care and availability of services provided by regulated health care professionals.

1.3 About the Joint Project Board Projects

A total of twenty-seven JPB projects have been approved, with twenty-six spread across the five regions, and one project that is provincial in scope implemented by the Provincial Health Services Authority. Each of the projects are different in scope and complexity; they are based on the realities and interests within each region, on different care models and are at different stages of development and implementation.

The variety of service delivery models for the twenty-seven Joint Project Board projects presents a challenge for interpreting and understanding the variety of project team compositions as well as for comparing lessons learned and challenges.

The projects can broadly be conceptualized as falling under a number of different service models, illustrated in Table 1 below, including distributed models where different clinicians work in multiple locations fairly independently; clinic-based care with outreach services (home visits, satellite clinics or virtually through telehealth); distributed models with a centralizing element (e.g. a person, tool or set of policies and procedures to integrate and coordinate care); clinic-based care; navigator models (teams play a supporting, facilitating, and coordinating role in clients' care journeys); mobile team models (teams working together to deliver services in many locations) or a mixture of the above models. These models are described more fully in section 8: client-centred care delivery models (and project-specific details on the service delivery models are included in Appendix A).

Table 1: Clinical focus and service delivery model type of JPB projects.

Clinical focus	Number of projects
Primary Care	7 (26%)
Mental Health and Substance Use	8 (30%)
Primary Care & Mental Health	4 (15%)
Chronic disease & home care	2 (7%)
Maternal care	1 (4%)

Service Delivery Model	Number of projects
Distributed model	4 (15%)
Clinic based with outreach	4 (15%)
Distributed model with centralizing element	3 (11%)
Clinic based	3 (11%)
Navigator	3 (11%)
Mixed	5 (19%)
Unknown	3 (11%)
Mobile team	2 (7%)

The clinical focus of the projects also varies, from a focus on primary care to prenatal care and birth, mental health and wellness, detox, home care and post-hospital discharge navigation. All projects attempt to address various barriers to health care access and many have additional focus on the social determinants of health through dedicated staff to help address other social issues or through strong linkages to other agencies and programs. Wellness, prevention and culture feature strongly in many of the projects.

All projects reporting in 2016/2017 served Status First Nations individuals. Nearly all projects (91%) reported serving all Indigenous individuals (including Métis, Inuit and non-Status First Nations). Nearly half (48%) of projects reported providing services to the general population as well. All projects reported delivering services in-community and 14 (61%) reported delivering services out-of-community.

1.4 About the JPB annual report template

An annual JPB report template has been collected since 2015/16 but was adapted in May 2017. The annual report template aims to collect an overview of project implementation, services delivered, accessibility and availability of services provided by regulated health professionals, challenges and successes. The template attempts to balance the need for

collecting high-level information of an evaluative nature while managing the reporting and evaluation burden for projects and JPB.

The annual report template is the only source of information of an evaluative nature being collected for the majority of JPB projects. Additional evaluation work will be conducted for five 'prototype' JPB projects (one in each region). A JPB Projects Evaluation framework document describes how the JPB annual report and additional prototype evaluations will feed into the overall JPB evaluation.

Project annual report templates were the main information source used to create this report, with some supplementary information gathered from historical project documentation and supplementary narrative reports provided by projects.

The changes made to the annual report template in May 2017 included some new quantitative questions related to the number of clients seen and total client visits. These questions were new and would have required ongoing tracking at the beginning of the 2016/17 fiscal year. Accordingly, Projects may not have been able to report these quantitative service delivery figures for 2016/17 but were asked to collect this information going forward. Thus, the number of clients seen in Section 4 is likely an approximation of the services delivered in 2016/17.

The annual report template will be adapted over time depending on the utility of information gathered and the likelihood of information to change over time.

Most (82%) of the 2016/17 annual reports were submitting by someone in the role of project lead/manager/developer. A further 30% were submitted by a Director; 26% by a Health Manager or Clinical Supervisor; 26% by an employee of the host agency; 8% by a Health Director and 8% by some other staff involved in the project (Medical Office Assistant [MOA], Community Engagement Coordinator).

1.5 Reporting coverage

- A total of 23 annual report templates were received for 20 out of the 27 projects across the province. Three projects had multiple annual report templates submitted by different individuals involved in different components of the project.
- Five projects submitted no annual report template.

- Four projects submitted a supplementary narrative report in an alternate format, which were reviewed and lessons learned extracted however, it was not possible to extract the quantitative questions asked in the annual report template.

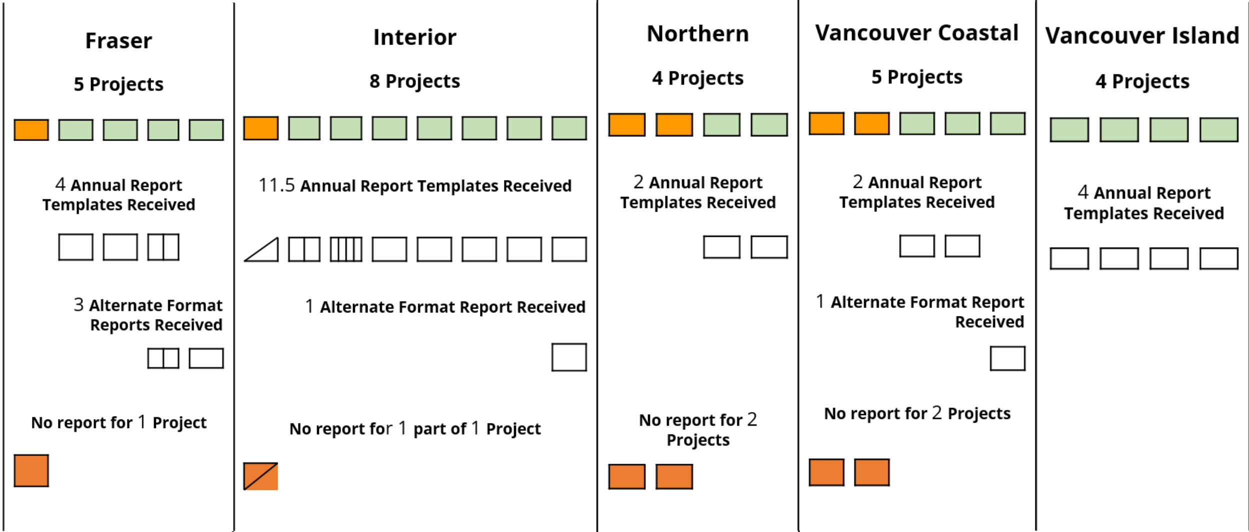


Figure 1: Among the 27 projects a total of 23 annual reports were received, 5 reports of an alternate format were received and no reports were submitted for 5.5 projects.

1.6 Limitations

This report draws on the information, discussions, and stories that 20 of the 27 JPB projects shared in their 2016/17 annual narrative reports. As such, any missing reports, data or lack of clarity in responses may affect the interpretation of the submitted data and its summarization. Having only 20 out of the 27 projects included in this analysis also limits the findings. Quantitative findings were compiled based on data submitted, which were not complete and included new questions that projects may not have been able to report the first year. As a result, quantitative questions relating to the number of services delivered is an approximation. Some projects submitted multiple reports and the categorical data (such as populations served) did not always agree across the reports. In other cases, the service model type was categorized based on the description of services provided rather than self-reported model type. The 2017/18 annual report template has been modified to eliminate questions that were not deemed to be of great utility, and to add additional questions to address areas that lacked clarity.

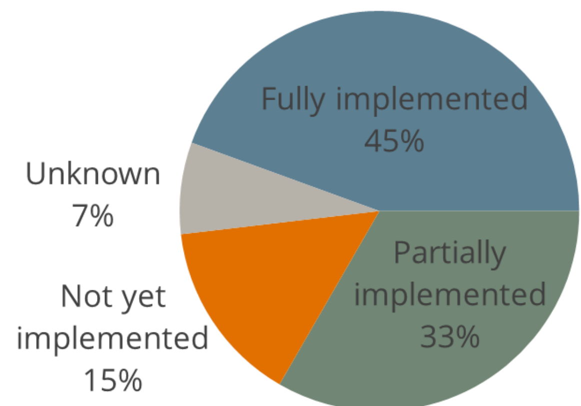
Section 2: Project implementation progress

2.1 Projects implementation progress

When examined at a high-level in terms of staffing, projects can be roughly categorized as not yet operational (no clinicians hired and no patients being seen); semi-operational (some clinicians hired and seeing patients, but not the entire project team); and fully implemented (all clinicians on the team hired and seeing patients [including projects with turnover during the year as long as a position wasn't vacant the entire year]).

When examined in this light we see that as of July 2017:

- 45% of projects were fully implemented (all clinicians hired and seeing patients [turnover during the year would still be considered fully operational as long as the position was not vacant the entire year])
- 37% of projects were partially implemented (some clinicians hired and seeing patients, but not the entire project team)
- 15% of projects were not yet implemented (no clinicians hired and no patients being seen) and
- One project (4%) was of unknown implementation status.



2.2 Recruitment, retention, and turnover

As of July 2017, 53% (59 out of 112) of JPB-funded FTEs were filled across the province.

Fraser and Vancouver Coastal have the highest percentage of roles filled among the regions with 58% and 85% of roles filled, respectively; however, these regions also have the lowest number of positions to fill (12 and 7, respectively; see figure 2 below).

The regions with the largest number of FTEs yet to fill are the North and Vancouver Island, which have 46% and 45% of roles filled, respectively; however, these regions also have the second and third highest number of FTEs to fill across regions (30 and 27, respectively) (see figure 3 below).

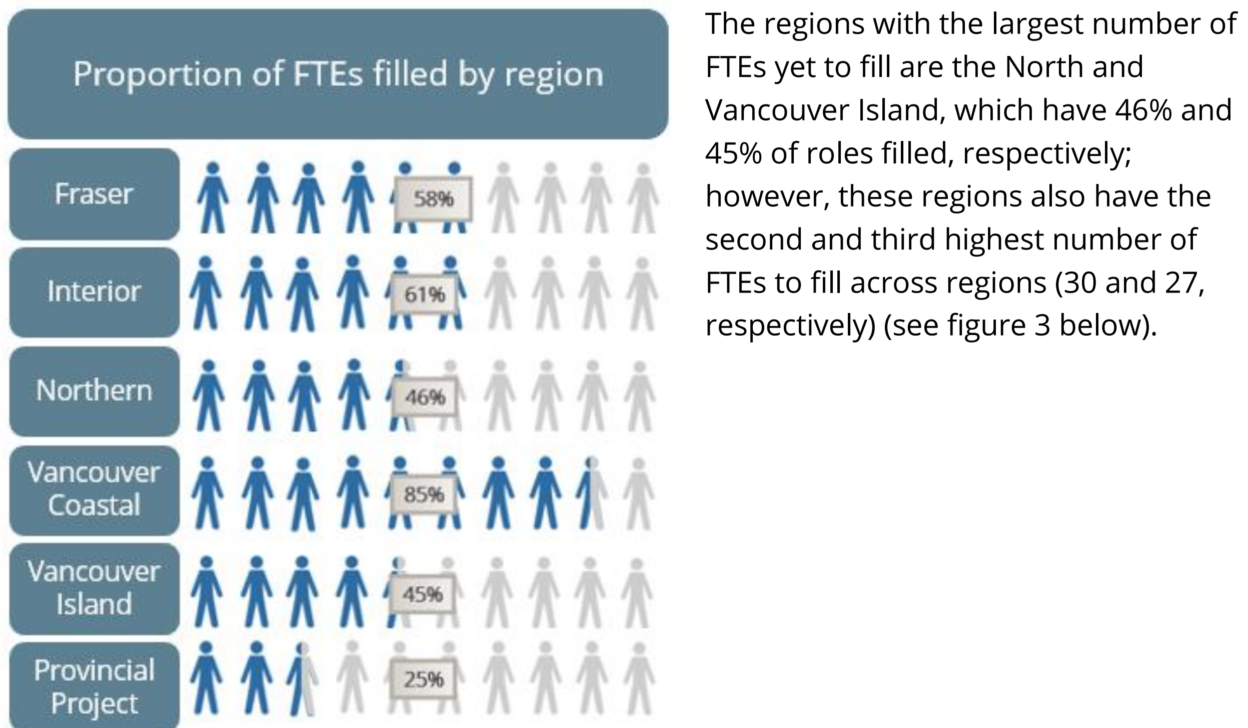


Figure 2: Proportion of JPB-funded full-time equivalents (FTEs) that were reported to be staffed at the time of reporting (July 2017) for each region and one provincial project.

In absolute numbers, the largest number of FTEs filled were the Interior (19 FTE), followed by the North (14 FTE), as shown in figure 3 below.

Based on information available in the reports received, 47% (53 out of 112 JPB-funded FTEs) of positions were unfilled as of July 2017. For 42% (22/53) of these positions, the reason the position is unfilled is unknown (dark green bar). At the time of reporting, there were several (26% [14/53]) positions waiting to be posted (blue bar), most of which were from the Vancouver Island region. Some (21% [11/53]) positions had turned-over (yellow bar) and others (11% [6/53]), mostly in the North, were in ongoing recruitment (orange bar).

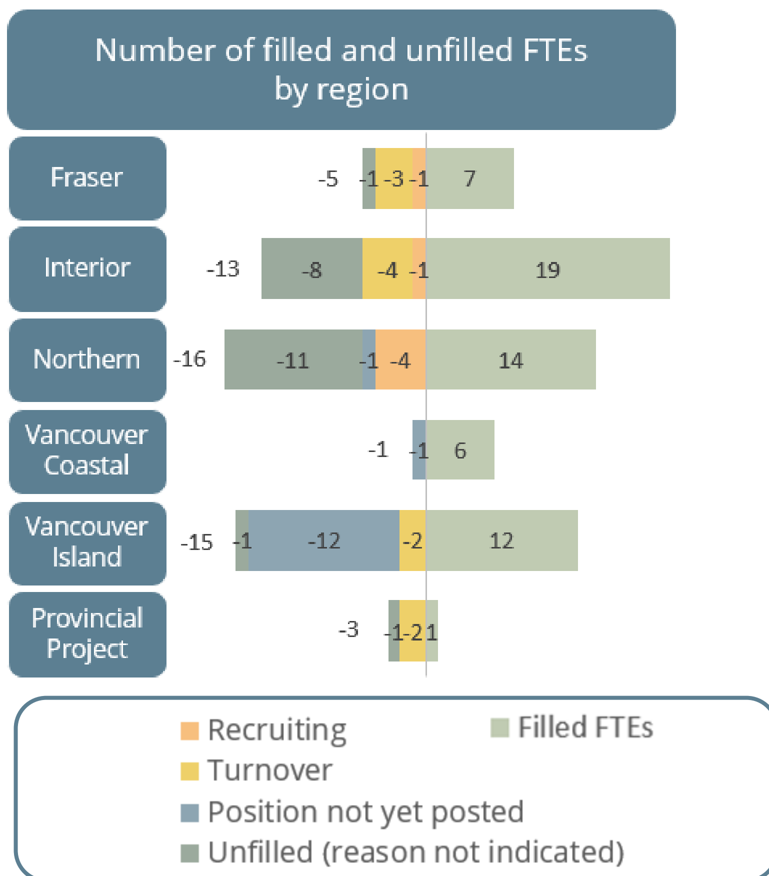


Figure 3: Breakdown of filled and unfilled JPB-funded FTEs by region. Filled FTEs are represented on the right side of the graph and unfilled FTEs are represented on the left side of the graph with negative numbers. Unfilled FTEs have been further broken down according to the reported status of the position (position not yet posted, in recruitment phase, vacated due to turnover, or reason not given or the information was not available in the reports.

All GP positions were reported to be filled. The lowest proportion of positions filled were among mental health & wellness professionals (36% filled, n=22), followed by social workers (47%, n=12) and nurses (51%).

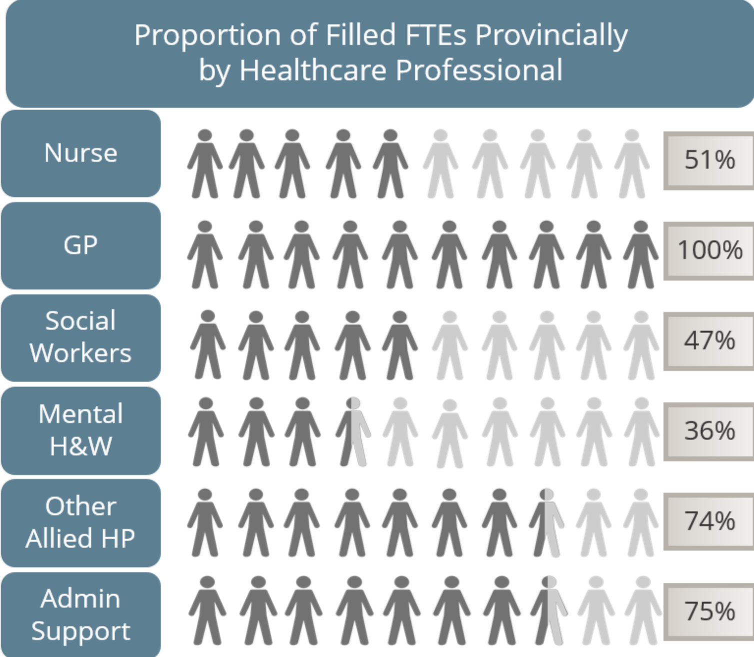


Figure 4: Proportion of positions that have been filled by provider type provincially as of July 2017. Other allied health professionals (Other Allied HP) include the following health professional designations: Dietician, Naturopathic Doctor, Traditional Chinese Medical Practitioner, OT, PT, ST, Podiatrist, and Pharmacist. Mental health and wellness practitioners (Mental H&W) includes: RCC, MHC, Psychologist, and Certified Addictions and Mental Health Counsellor.

2.3 Constraints to project implementation

Projects reported constraints to implementation in four common areas: infrastructure, recruitment and retention, funding and performance issues and provider logistics. Table 2 on the following page provides an overview of these commonly reported implementation issues.

> "We continue to work out of the Tribal Council Office and have grown into a team of our own."

Infrastructure issues and recruitment of health care staff were among the most commonly reported project implementation issues. Provider logistics issues were reported less frequently, likely because many projects are still in the early phases of implementation.

Recruitment of clinicians

When asked to describe their 'top' implementation issues, projects indicated that recruitment of clinicians was their primary issue. These issues, and the steps projects have taken to address them, are explored more in section 4.1.

Complexity & length of project implementation tasks

Another 'top' implementation issue theme was the complexity and length of project implementation tasks. The tasks reported included negotiating scope of practice and supervision, building relationships with communities, building relationships with partners and clinicians, negotiating contracts with Bands, weather or crises in community that delayed project start-up and funding delays from the FNHA.

> "Investment in time to ensure Contract negotiations between the HA and the Bands were collaboratively reached was essential. This took considerable investment in time. The addition of the JPB contract made for lots of moving parts and significant time to understand all the nuances."

Funding

Projects also mentioned issues relating to the rollout of project funding, the criteria around eligible use of funds, the level of funding provided and delays in approval processes for reallocation of funds.

Eligibility criteria, for example, did not include the "cost of providing housing for visiting health care professionals; burden of coordinating housing and schedules for HCP (need to be part of a job description for an administrative position, with adequate time allotted); cost of paying wages and benefits to keep up with industry standards, staff recruitment and retention".

> "there was a concern that the initiatives were set up to fail because the funding was so minimal for the establishment of [the project]."

Having project funding divided into multiple segments that arrived at different times made it difficult for program leads to plan and difficult to accomplish goals for their fiscal year if the installments came later in the year.

Table 2: The most commonly reported implementation issues by projects included IT issues and a variety of provider recruitment and retention issues. Funding and provider logistic issues were further down in the list of implementation issues.

Infrastructure Issues	Recruitment & Retention Issues	Funding & Project Performance Issues	Provider Logistics Issues
1. IT (e.g. Bandwidth, EMR) (48%)	**2.** Length of time to hire (e.g. developing job description, posting job, signing contract, setting up workspace) (41%)	**5.** Funding conditions (26%)	**7.** Provider uses up all of their time travelling (15%)
4. Lack of physical office space (30%)	**3.** Lack of trained candidates in the area (37%)	**6.** Insufficient time for project planning (19%)	**7.** Provider unable to access community due to weather (15%)
4. Lack of confidential clinical space (30%)	**3.** Unable to attract local qualified candidates (compensation issues such as pay, benefits, seniority) (37%)	**7.** Project goals and objectives are not clear/agreed upon (15%)	**8**. Lack of short-term housing/accommodation (11%)
7. Lack of confidential file storage (15%)	**5.** Unable to attract staff based on the service level required (e.g. 0.2 FTE) (26%)	**7.** Distribution of funding among multiple funding partners for shared services (15%)	**8**. Provider does not have the tools they need (11%)
	6. Union matters (19%)	**8.** Project roles and responsibilities are not well articulated or understood (11%)	**9**. Provider spends too much time on administration (7%)
	7. Lack of management/supervision resources (15%)		**9**. Provider travel costs are too high (7% of reports)
	9. Inability to retain staff (7%)		

Section 3: Access to health services

Projects reported access barriers faced by clients and communities that broadly fall into the following six dimensions of access: flexibility of services; awareness of services; availability of services; fragmentation of services; quality of care; and cultural safety & trust. Note that this is not an exhaustive list of the dimensions of access; rather, the dimensions presented here have been selected based on predominant themes that emerged in projects' discussions of access barriers and corresponding mitigation strategies.

In subsequent sections of this report, we explore several ways that projects are targeting these dimensions of access, including through increasing service delivery by regulated health professionals (section 4), interweaving wellness & culture (section 5), quality of services (section 6), coordination & integration of services (section 7), client-centred care models (section 8), and through investments in partnerships & collaboration (section 9). Projects have described strategies for addressing access barriers that extend into each of these areas.

> "Every door is the right door"

Figure 5 below presents a summary of the alignment between the different dimensions of access (depicted in the inner circle of the diagram) and strategies and approaches projects have reported using to target these areas. For example, increased service delivery by regulated health professionals (black ring) has contributed to improvements in the availability of services, the capacity of services to accommodate client and community needs, and has reduced the stress burden on service providers to allow for more time spent with clients and improved quality of care.

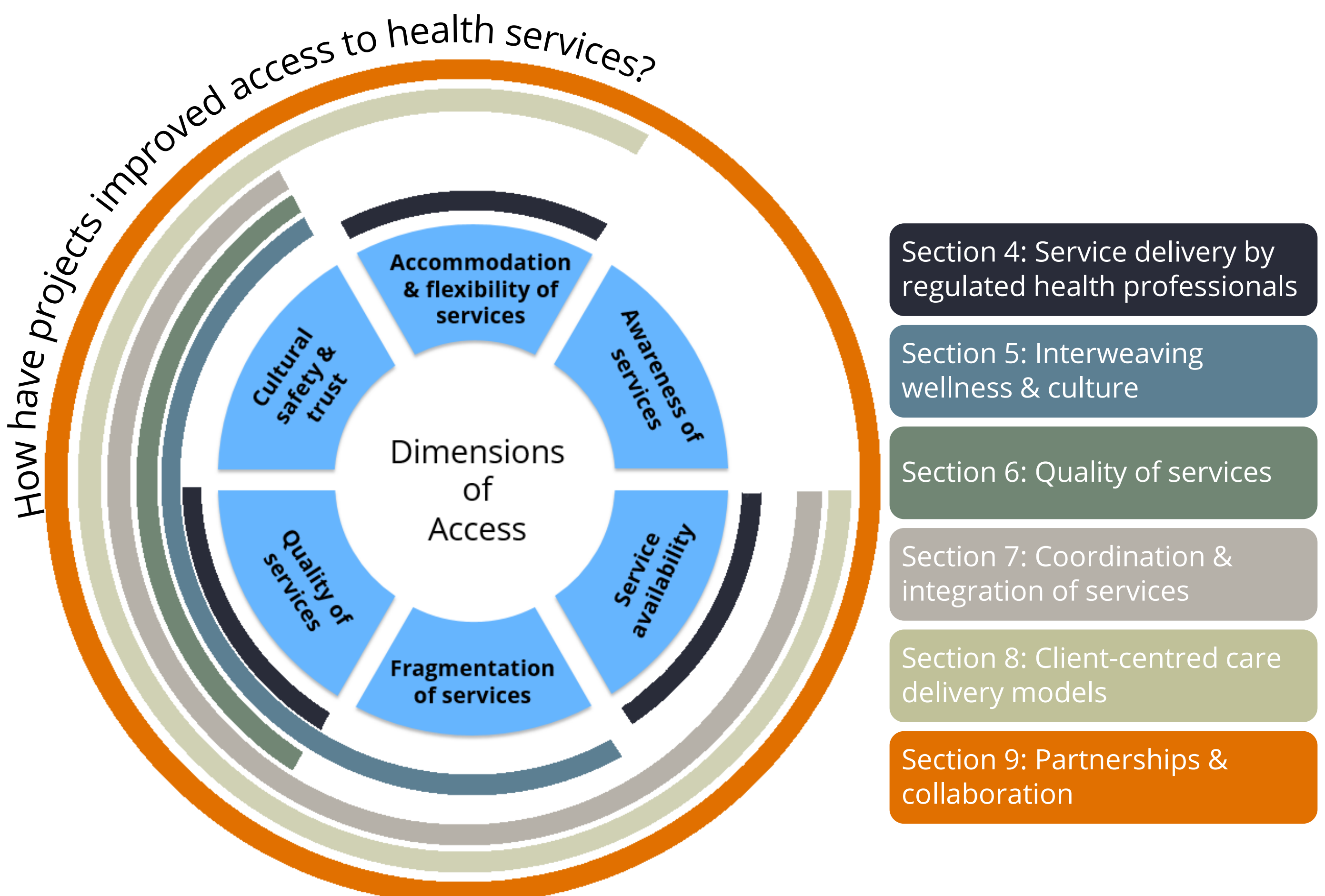


Figure 5: Dimensions of access and mechanisms projects have employed to facilitate each of these dimensions.

3.1 Access barriers and mitigation approaches

The rest of this section briefly explores each of these dimensions of access and highlights ways in which projects have been addressing and attempting to facilitate this type of access.

Fragmentation of services

Several projects (n=8) reported fragmentation of services as an access barrier and described different manifestations of service fragmentation that clients face. Limited integration of services influences how readily clients move between health services and impacts continuity of care. Projects also described how fragmentation of services contributed to disruptions in communication and information flow and led to "silos in patients' care and lack of coordination and communication between the silos".

> 80% of projects reported that they 'agree' or 'strongly agree' that "as a result of this project, access to care has improved".

Mitigation strategies: Projects have been contributing to greater integration & coordination of services and this theme is explored in more depth in section 7.

The introduction of navigation and coordinator positions has been improving the coordination of services and has supported clients and their families in navigating complex care pathways they may encounter. These health care professionals support this through case management, care pathway planning, advocating for clients and by managing information and communication flow between service providers and across organizations.

> ""The [care team] will connect with resources/providers in community before and after discharge to try and smooth the transition for the patient and family and ensure that their needs are met."

Building relationships, strengthening partnerships, and fostering collaboration among different actors within the network of care and services has also been a key mechanism for addressing fragmentation of health services. One project described how their team members attended patient rounds at the hospital in order to play an active part in the care delivery and coordination. Another project described developing a collaborative network of individuals from MCFD (Ministry of Child and Family Development), the School District, the RCMP, and other health organizations to link with services beyond the health sector.

Client-driven care delivery models, such as community-based and mobile care delivery and integrated care teams, have improved the availability of professionals and facilitated collaborative, holistic, and client-centred care delivery that is delivered in locations that are more accessible to clients in terms of both proximity and acceptability (deemed 'safe' spaces).

> "Establishing primary care clinics … on-reserve provides significant advantages to First Nations community members because they can access many other services from the Health Department thereby providing wrap-around care."

Service availability

Service availability was another frequently mentioned barrier to access, reported by over half (11/20) of projects. This included physical availability: distance, geographic location, and challenges securing transportation (reported by 9 projects); and resource availability: limited availability of health care providers and demand for services exceeding availability (reported by 7 projects).

Mitigation strategies: Client-driven care delivery models, including community-based, mobile care delivery, outreach teams, and home visits, and the establishment of new points of care introduced by JPB projects, have brought services closer to clients and communities. In some cases, projects are using band-owned spaces and facilities for care delivery.

Other projects are addressing financial barriers to care directly, by eliminating fees for the completion of some health care paperwork (e.g. addiction treatment referrals), or indirectly, by bringing services closer to home or targeting transportation challenges. Transportation arrangements include coordinating transportation or community drivers for clients, providing gas vouchers, and working with existing travel programs, such as community travel programs and the FNHA First Nations Health Benefit Medical Transportation program.

Projects have also described using various technologies, including EMR, eHealth, MOM2, voice encryption software and telehealth, to mitigate distance barriers or extending hours of operation to make services more available to clients who are unavailable during the day.

> "We have all of our communities covered for the first time".
>
> "This service has allowed the communities access to Primary Care Services that they did not have in the past."
>
> "This project has allowed increased capacity for the [Nation] and [Nation] clinics to now open five days a week (through multiple funding streams) allowing improved access to services."

> "One [team/program lead] identified that there are a lot of low income community members who in the past were not funded to go and get their prescriptions and they had major transport barriers. With the clinic being on reserve it is a lot easier to be prescribed something onsite. At one clinic the local Pharmacist delivers prescriptions to the homes of community members so they can explain them. Prescriptions are more easily accessed now which never would have happened in the past."

Another dimension of service availability described by projects is demand for service exceeding supply resulting in long wait times.

Mitigation strategies: Increased number and availability of regulated health care professionals, through filling of JPB-funded positions, is contributing to reducing this barrier. However, some projects report health care professionals being overburdened by their caseload, or the complexity of the needs of their caseload, and have requested funding for additional human resources. Integration & coordination of services and partnerships & collaboration have also played a role in leveraging existing community, local, and regional resources and services to bridge gaps in service availability (see section 9.1 for examples of the types of contributions partners are bringing to the table).

Accommodation & flexibility of services

Several projects (n=7) reported lack of accommodation and flexibility of services as an access barrier for clients. Access barriers pertaining to service accommodation and flexibility included: opening hours and locations that are inconvenient, inappropriate, or that require significant wait times for clients; challenges for providers contacting clients and vice versa if clients are mobile and/or do not have a phone; and point of care locations that are not appropriate or not safe for clients due to fear of stigmatization, requirements of being away from home for extended periods, or isolation from community and support systems.

"The clinician is able to meet clients in a mutually agreeable safe place. This may include going for a walk outside, at school, at a relative's home or a home visit."

"Lack of immediate access to initial Dr appointments has deterred Aboriginal clients from accessing services, as the wait feels long, and help is requested immediately. Solution: Adding 2 drop in Dr apts each week for solely Aboriginal clients for faster access to [program referral]"

Mitigation strategies: In general, the client-driven care delivery models used by many of the projects are, by design, better positioned to accommodate and be responsive to client needs and preferences, particularly in terms of the locations and spaces where care is delivered. A few projects described adding drop-in appointment slots to reduce wait times and to be responsive to urgent cases or referrals. An increase in the availability of health care professionals has also reduced the burden on existing human resources to enable more flexibility of service providers.

"Physicians welcome the client and also the client family to appointments. So, if the client attends an appointment with her children who also have health needs, the physician will address the needs of all family members who are asking for help. This reduces the need for clients to return to the clinic for multiple appointments.

Projects described examples of how accessibility of care is being supported by service providers' flexibility in areas including: hours of availability (extended or non-traditional hours); meeting location with clients (in-community, home visits, or other locations outside of established point of care); and options for being reached outside of service hours (contact information made available to clients).

Awareness of services

Some projects (n=3) indicated that lack of awareness has been an access barrier.

"JPB staff participate in Nation Events to ensure visibility and knowledge of the programs offers."

Mitigation strategies: Projects have been mitigating this barrier through community engagement, awareness campaigns, and outreach activities. Projects have designed and implemented awareness campaigns including telehealth promotion, bringing information booths to community events, Facebook campaigns, and posters. Efforts to build and strengthen relationships and trust with communities, such as participating in community events and meetings, have also served to increase awareness of services. One project described an idea of developing a volunteer email or texting campaign to inform local community members of the next time services will be coming to the community.

"Client word of mouth has been the most effective way to increase our patient panel. We're very thankful for the kind recommendations of our clients to refer their friends and family to the clinic."

"The [navigator positions] have worked in collaboration with the [regional team] and the Regional Nurse Manger to raise awareness of the Nurse Navigator role. A [navigator role] Educational Pamphlet was developed and distributed to clients and partners to enhance and promote awareness of the .. role and services available"

Interpersonal quality of care

Projects (n=8) have described access barriers for clients that include limited opportunities for relationship development with service providers, lack of pre-existing relationships with service providers, service providers not having time for explanations or to explore complex issues, and previous experiences of poor treatment by service providers.

"Alternate payment allows more time spent and focus on more than one issue."

"clients have reported repeatedly that they feel our physicians truly care because they do not feel rushed in the healthcare encounter."

Mitigation strategies: Building relationships and trust between service providers and clients and communities has been emphasized by projects as a strategy for reducing access barriers. Projects have invested time in building trust with clients and communities. For example, providers have been attending community events and activities so that community members become familiar with providers.

Some projects have opted to move away from fee-for-service payment in favour of provider remuneration models that are more aligned with client-centred care. Projects have also described prioritizing continuity of care to support relationship building over time, including through proactive follow-up with clients.

"Creating an accessible primary care model in community – in a non-FFS funding model – has provided huge benefits to patients with complex needs who would otherwise visit walk-in clinics or not access good care at all"

"[…] improvements in [Nation] health for current and future generations will not improve with improvements in health services alone. Elders have clearly stated that healing must also come from the culture and traditions of the People."

Cultural safety and trust

Half of the projects (10/20) reported inadequate cultural safety and trust in health services and providers as one of the main access barriers faced by clients.

"Trust" has been grouped with cultural safety because often clients' or communities' mistrust or fragile trust in the health system stems from previous culturally unsafe experiences, and/or anticipation of culturally unsafe care.

Privacy and confidentiality concerns were also described as a factor influencing client trust in services. Client privacy and confidentiality is particularly relevant when working with different partners, using community spaces and facilities, and when implementing and integrating EMR systems.

Mitigation strategies: Projects have been engaging in efforts to improve the cultural safety of client experiences at patient-provider levels, community levels, and among other (non-JPB project) health service providers and organizations.

Projects have emphasized the importance of building relationships and trust, between both clients and providers and communities and health services, for quality, access, and cultural safety of services.

Several projects have been providing cultural competency and cultural safety training for staff. Other projects have described supporting the delivery of cultural competency training and workshops for other local non-First Nations service providers and organizations. Many of the navigators and health coaches have taken on the role of supporting and advocating for clients as they access health and social services beyond the direct reach of the project.

Partnerships with communities were described as a critical facilitator of strengthening cultural safety within projects. Projects described building community trust in care providers through commitment to relationship building, participating in community events, turning to communities to evaluate the cultural safety of services and providers, and working with communities to establish culturally safe locations for service delivery and outreach.

85% of projects reported that they 'strongly agree' or 'agree' that "as a result of this project, cultural safety and humility of care has improved".

"We did not foresee that some community members would not want their local community health service involved in their discharge or circle of care. This has led to challenges of trust, communication as well as privacy and confidentiality issues."

"Working with local FN communities to build trust with specific care providers. Local FN communities can assist with assuring clients the care provider is culturally safe and appropriate and can be trusted."

"The project has taken great care in ensuring client confidentiality is maintained in accessing service. In addition, our [regional health authority] Knowledge Exchange Leader has provided various Compassion and Healing Circles around issues related to stigma."

"Clients do not want to access services at a band office"

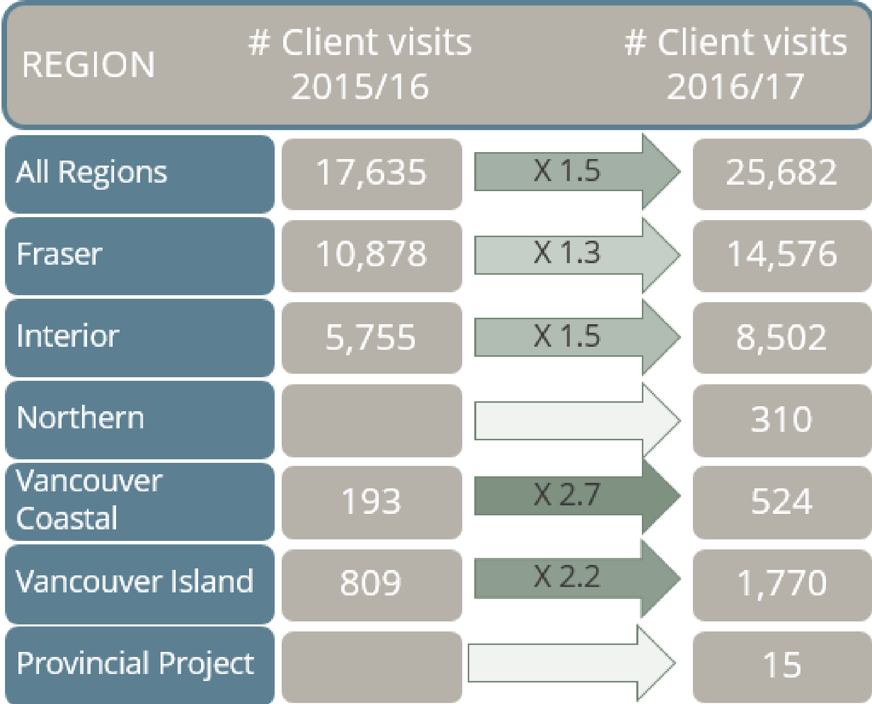
"The project has taken great care in ensuring that services are delivered in culturally safe locations as identified by local communities. The model of care is outreach to locations that FN communities have indicated are appropriate and accessible by members of their community."

Examples of steps projects have taken to address client confidentiality and privacy concerns include: providing mandatory privacy and security training when introducing a new EMR system; pursuing voice encrypted software for clients to communicate with providers remotely; and discreet service provision through home visits or providing services in town.

Section 4: Service delivery by regulated health professionals

Provincially, there has been a 1.5 times increase in the number of client visits between the 2016/17 and 2015/16 fiscal years for a total estimated 25, 682 client visits across all projects in 2016/17. Note that these estimates do not include all JPB project activities such as outreach, community training events, and meetings. The highest increase in client visits has been in Vancouver Coastal, with a 2.7 times increase for a total of 524 client visits. Vancouver Coastal had the lowest number of clients seen in 2015/16.

It is important to note that many projects were in early development stages during the reporting period and a new annual reporting template was rolled out for 2016/17. Because of this, several projects did not have estimates for client visits over the previous year. These figures also do not include 5 out of the 27 projects that did not submit an annual report template. Therefore, these clients visit numbers reported are an underestimation. Nonetheless, increases were seen in client visits for each region where these values were available.



REGION	# Client visits 2015/16		# Client visits 2016/17
All Regions	17,635	X 1.5	25,682
Fraser	10,878	X 1.3	14,576
Interior	5,755	X 1.5	8,502
Northern			310
Vancouver Coastal	193	X 2.7	524
Vancouver Island	809	X 2.2	1,770
Provincial Project			15

Figure 6: Provincially there has been a 1.5 times increase in the number of client visits in 2016/17 vs. 2015/16.

4.1 Staffing challenges and mitigations strategies

As described briefly in section 2, recruitment of providers has been the most significant implementation issue faced by projects. The issues are varied, from the length of the hiring process, to challenges in finding appropriate and qualified candidates, challenges of hiring in a remote location and union issues. Despite reported challenges in recruiting professionals many projects praised the quality of their staff and their resiliency and their impact on project success. The following section outlines the key challenges and mitigation strategies employed by projects to overcome these issues.

> "All of the members of the [..] team are resilient, hard working, talented professionals, knowing they may not arrive or leave a community when planned due to weather and other transportation complications common to visiting remote areas, and sometimes not knowing where they will find a bed"

Inability to attract local qualified candidates

Difficulty in identifying appropriate or lack of trained candidates was a major challenge reported by over a third of projects (37%).

The average recruitment time varied across different health professionals (see figure 7 below). The longest average recruitment was for nurses (10 months), followed by social workers (6 ½ months), mental health & wellness workers (5½ months), admin support workers (4½ months), family physicians (4½ months) and other allied health professionals (2½ months).

> "The most significant challenge has been to recruit qualified and appropriate candidates who are a good fit and understand working in a First Nations context in a culturally safe and respectful manner".

Given that nurses, mental health & wellness professionals, and social workers are also the professions with the lowest percentage of positions filled provincially (51%, 36% and 47%, respectively) more detailed analyses of the factors and supports that could aid in recruitment would be helpful.

Mitigation strategies: Projects have attempted to work around the lack of local qualified candidates by:

> "[First Nation community] reallocated funds to increase the amount of funds available so that an RN would be hired rather than an LPN, who would require more supervisions and possibly impact the workload of the FNHA funded treatment nurses."

- Contracting with health professionals rather than hiring into a full-time or part-time position.
- Reallocating funds for one profession to another profession that is more available locally and still in-line with local needs. One project hired an RN rather than an LPN to minimize clinical supervision requirements. Another project took the funds for a GP and hired another clinician type and admin support. Other projects suggested this approach but noted the JPB project funding criteria to fund regulated health professionals only as being a barrier.
- One project highlighted a number of initiatives aimed at increasing the number of new professionals working in First Nations communities, including:
  - Collaborating with a university to place first year medical students in communities for cultural experiences and learnings early on in their careers in hopes to improve retention of physicians in communities
  - Advocating to increase residencies in First Nations communities for physicians and other professionals
  - Supporting a First Nation health scholarship program with educational institutions to support First Nation pursuing health careers
  - Holding a youth health career gathering
  - Inclusion of FNHA staff on physician recruitment table
- Other potential strategies to mitigate this challenge could include promoting secondments or interchanges between health authorities and local communities to build experience, cultural safety, relationships and supplement local capacity.

Lack of provider housing

The lack of housing for providers to stay, either permanently or when travelling to a community to provide services, is a challenge for several projects.

Mitigation strategies: One project developed a listing of housing and provided tours of the facility and housing options for potential candidates. Another project is working on a rental house in a community for contractors to stay in.

Union & seniority issues

Various union issues were raised by projects. One project mentioned, in retrospect, the value of having a position under a union. Another project mentioned the difficulty in recruiting Indigenous individuals into union positions because of seniority requirements. Another mentioned the difficulty of having flexible hours or responding to crises as a union issue. More generally, another project cited the lack of portability between health authority contracts and FNHA contracts as a challenge, although this would not be an issue applicable only to unionized positions.

> "The [...] position was originally an excluded position but in hindsight it needs to be under the BCNU as this allows for better conditions for the RN such as coverage under the union, maintaining seniority and a pay scale that is aligned to equivalent RN roles throughout [regional health authority]."

Mitigation strategy: No mitigation strategies for this issue were described by projects however a recommendation of this report is a review of challenges for hiring, particularly for nurses, social workers and mental health & wellness professionals to identify provincial level efforts that could support recruitment efforts (e.g. possibility of supporting secondments and interchanges between partner organizations).

Working alone policies

Two projects mentioned the need to adhere to 'working alone policies' as an issue for staffing. In one urban example, the community had to supplement funding to increase an MOA from a 0.2 FTE to a full-time position in order to assure that no health professionals were left alone in the clinic for safety purposes. Another rural project mentioned that in some cases a home visit risk assessment might prevent staff from doing a home visit alone.

Mitigation strategy: The urban project supplemented the MOA position with their own Nation's funds in order to hire a full-time MOA. FNHA staff (including JPB-funded positions) use a service called *Replay Message Centre* for employees travelling or working alone to check-in after their visit/shift/travel is complete. If employees fail to call-in, the service follows-up with the employee and their list of emergency contacts until the employee is located.

Length of hiring process

Human resource department delays contributed to recruitment challenges for some projects. Average recruitment times for project health care professionals varied across regions, from 2.1 months in Vancouver Coastal to 14 months in the Northern region (figure 7a), and across health care professional types, from 2 months for other allied health professionals to 10 months for nurses.

Mitigation strategies: Higher-level support to move human resource processes and issues forward aided in some cases. Contracting services also circumvents any human resource department delays.

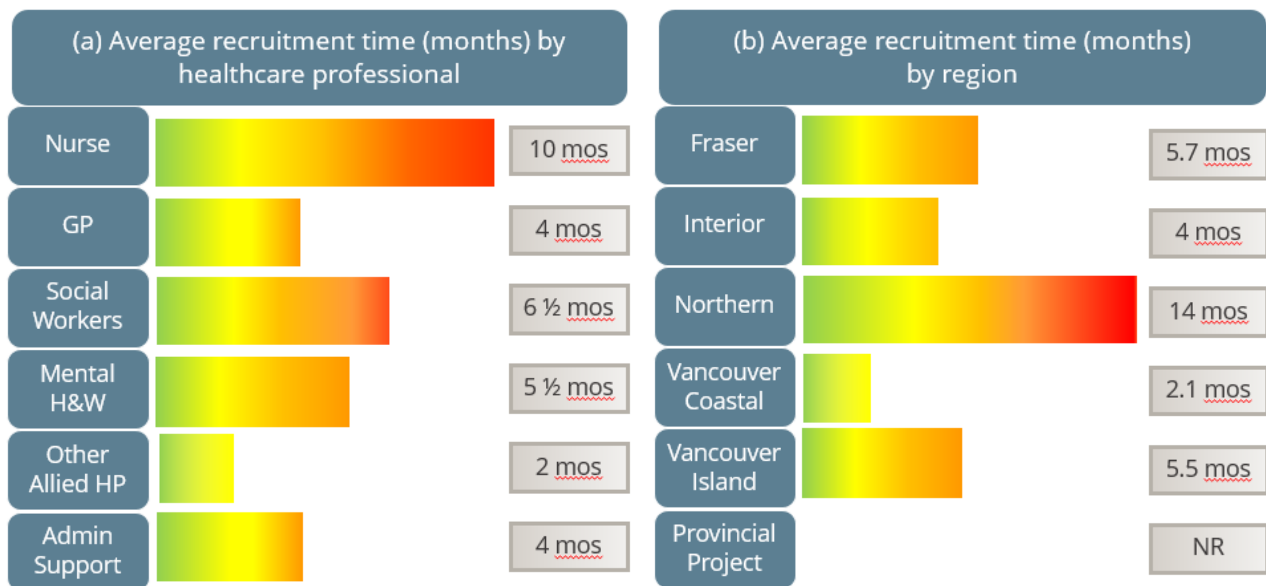


Figure 7: Average recruitment time (in months) for JPB-funded positions reported by (a) region and (b) health care professional type. Other allied health professionals (Other Allied HP) include the following health professional designations: Dietician, Naturopathic Doctor, Traditional Chinese Medical Practitioner, OT, PT, ST, Podiatrist, and Pharmacist. Mental health and wellness practitioners (Mental H&W) includes: RCC, MHC, Psychologist, and Certified Addictions and Mental Health Counsellor.

Retention & Burnout

The retention of staff will be an increasingly important consideration. Even in these early days of project implementation, several projects mentioned the risk of burnout or "employee compassion fatigue" for staff, particularly for clinicians who have a high number of complex cases and a relatively small number of colleagues because of the difficulty recruiting staff.

> "These staff are perceived by others as 'experts' on Indigenous issues and they are continually called upon to advocate for the same and to confront/address issues where cultural safety is compromised."

> "In traditional organizations such as hospitals, these change agents are continually required to 'blaze new trails' and the effort and energy this takes is high. Embedding culturally appropriate methods of regular "check ins" and ways of supporting these change agents into new programs is important."

Mitigation strategies:

- Splitting positions across several individuals (one project split one position across four clinicians that all live in different communities, another filled a 2.5 FTE with 3 individuals).
- Continuing efforts to fill vacant positions or, where positions are filled but levels of need outstrip resources, continue requests for funding for more staff.
- Providing Elder supports or developing a support network for Indigenous health employees.
- Limiting / decreasing caseload. One project limits the number of crises calls that the clinician responds to and refers to alternate service providers. They also have limited the number of eligible hours a client may receive within a fiscal year (after two months of weekly counselling sessions, clients are moved to bi-weekly meetings).
- Hiring locally to reduce travel time.
- Providing group programming when possible. One project attempts to "do group education workshops when possible for most efficient use of time i.e. anger management, grief and loss, mental health and wellness educations sessions".

- Providing adequate professional development funds and activities. Several projects mentioned the importance of professional development for their staff and highlighted how they are sharing educational resources or funds across their program communities or having access to continuing education through partnerships with other organizations.
- Providing a holistic set of services. One project described how having empowered clinicians, with access to a broad range of services to address the holistic needs of clients supported job satisfaction and reduced burnout among their team.

Management time dedicated to human resource functions

A repercussion of the amount of time being spent on HR is that it takes staff time away from other critical project tasks.

Mitigation strategies: One project mentioned the desire to split the Health Management position into two separate roles: one that would focus on Health Administration (finances, human resources, policy development) and another on Health Projects (project management, communication, engagement).

Section 5: Interweaving wellness & culture

Although the nature of JPB project funding was aimed at increasing access to regulated health care professionals, many projects naturally, or through additional funding streams, have integrated other dimensions of wellness or culture into their service model.

5.1 Integration of the First Nations Perspective on Health and Wellness

Projects highlighted five main facilitators for integrating the First Nations Perspective on Health and Wellness. Within each of these five areas, projects reported specific strategies for bringing these elements into practice, as shown in table 3 below. A brief summary of these approaches and strategies are given in this section.

> 95% of projects reported that they 'strongly agree' or 'agree' that "as a result of this project, wellness is integrated into the delivery of care".

Table 3: Approaches to integrating the First Nations Perspective on Health and Wellness described by projects.

How have projects integrated the First Nations Perspective on Health and Wellness?	
Broad Approaches	**Specific Approaches**
1. Providing holistic, client-centred, and integrated care	• Integrated care teams • Non-FFS funding models • Social determinants of health approach
2. Honouring and integrating local, cultural, and traditional wellness methods and teachings in care and services	• Working with Elders, cultural knowledge keepers or having dedicated staff to focus on culture • Two-eyed seeing approach • Learning and respecting each community's protocols
3. Grounding in First Nations driven and delivered services	• Employing self-identified Aboriginal staff • Integrating services into existing First Nations health organizations • Community-driven service delivery and design
4. Supporting access to culturally safe, trauma-informed care and building a supportive network of services	• Providing cultural safety, cultural competency, and trauma-informed care training, workshops and information to project staff and partners
5. Building on strengths and restoring trust and relationships with individuals and communities	• Prioritizing relational care • Community engagement

Providing holistic, client-centred and integrated care

Projects highlighted integrated care teams that take holistic and social determinants of health approaches to "supporting the whole person" as a critical piece in integrating the First Nations Perspective on Health and Wellness into care and service delivery. Non-fee-for-service provider remuneration models were also reported to be supportive of this approach to care.

> "They [clients] are asked about there they want to start in their wellness journey."

> "We continue to have a need to develop a team based approach to care that includes multiple disciplines and includes traditional healers as part of the treatment team to promote mental wellness and substance use treatment."

Honouring and integrating local, cultural, and traditional wellness methods and teachings in care and services

Projects have described working with Elders and other cultural knowledge keepers and taking the time to learn and integrate the unique protocols of the communities they serve to bring community, cultural, and traditional wellness perspectives and teachings into their services. Other projects have dedicated cultural roles in the team such as a cultural liaison who "coordinates and provides cultural supports to the JPB clinicians and to health and social service providers in the territory".

Projects also described a two-eyed seeing approach to drawing on strengths from Western and First Nations perspectives health and wellness. One project in the Interior provides after hour support to the ER for any individuals who require cultural supports.

> "Wisdom, with the focus on medicine, culture, tradition and language, is addressed through supporting connections with elders and cultural knowledge keepers."

> "Clients are encouraged to use traditional methods of personal wellness – sweat lodge, drumming, praying, smudging etc. [clinician] respects the protocols of each community."

> "There is a direct attempt to blend two approaches, western psychiatry and substance use modalities blended with First Nations perspectives on spirituality and the importance of local cultural practices and traditions in maintaining mental wellness."

Grounding in First Nations driven and delivered services

First Nations driven and delivered services were also described as a critical element in integrating the First Nations Perspective on Health and Wellness into services. Projects have described the planning, implementation, and evaluation of services as being community driven and centred on community needs and priorities. A couple of projects described integrating services within existing local First Nations health centres and organizations as supportive of integrating culture and wellness into practice.

> "Our approach in asking questions about how our program would best serve these communities empowers Aboriginal clients and leaders to take their own power back in accessing recovery programs in a way that best fits their unique community's needs."

Supporting access to culturally safe, trauma-informed care and building a supportive network of services

Acknowledging, honouring, and integrating First Nations perspectives on health and wellness is part of moving towards provision of culturally safe care and these efforts were often described in conjunction. Projects also described working with other health and social service providers and partners to strengthen the collective cultural safety of community services and resources.

Building on strengths and restoring trust and relationships with individuals and communities

Building relationships and trust at both individual and community levels was described as a necessary foundation for bringing community wellness teachings and practices into services. To do this, projects have placed an emphasis on relational care and community engagement.

> "We do our best to build trusting relationships with clients and people who are interested in our services. We follow [Nation] protocols with our Elders and families."

> "The focus of the [care team] is on enhancing the strengths of Indigenous patients/families while supporting self-determination."

Section 6: Quality & patient experiences of care

As projects are, for the most part, in the initial stages of implementation there are fewer results to share that speak to longer-term outcomes that the JPB projects hope to achieve such as improvements in health outcomes or in improvements in quality of services.

The annual report template did not collect project-specific information on patient outcomes, quality or quality improvement initiatives but some projects mention their efforts in this area.

> "This project has had very strong positive support from community members for the establishment of the clinic. It has improved access, created a safe and welcoming environment, and given clients a positive experience."

One project described the reduction in ER visits as a result of their work, another spoke to how clients are seeking treatment sooner.

Examples of quality improvement initiatives and processes that projects described:

- Hosting workshops on continuous quality improvement for all Health Centre staff where "quality improvement tools were introduced and applied to challenges identified by workshop participants".
- Soliciting feedback from clients and program participants through evaluation forms and surveys
- Carrying out program evaluations to guide iterative program development, adaptations, and quality improvement
- Collaborative approaches to program design, development, and improvement that bring together community and project staff

> "To provide a program that will best meet community needs, mobile treatment counsellors, the program director, and continuing care coordinator meet with Community Health staff and/or NNADAP workers prior to the program start date to ascertain community needs and cooperatively design the most effective three-week program."

Several projects mentioned pride in their service levels or service experience for patients or described the quality improvement approach they are taking in their programming.

> "We provide medical services that are open to the public in addition to our status Clients. This is an opportunity to bridge the gaps between First Nations only clinics and the general public showcasing the level of service we provide"

Section 7: Coordination and integration of services

Although the twenty-seven JPB projects span several different models of care delivery, integration and coordination of care are common elements that projects report supporting.

A fundamental building block to coordination and integration mentioned by numerous projects was a solid foundation of partnership and collaboration, which is a topic area explored more fully in section 9 and through a number of practical tools, resources and supports to promote the integration and coordination of care

Projects report the following Partnerships and Collaboration tools, resources and supports to promote integration and coordination of care, which are explored more fully in section 9 below:

- Investing time in building relationships & meeting regularly
- Commitment
- Splitting positions across organizations
- Presence of governance structures that support collaboration and define conflict resolution pathways
- Formal Agreements
- Community engagement

Projects report the following practical tools, resources and supports that promote the integration and coordination of care

Clarity on service model, client population and roles and responsibilities

Discussing and clarifying key aspects of the service model, population served and the roles and responsibilities of providers and partners was an important element for coordination and communication and took a significant amount of time for some projects.

"The understanding of the project and what it is aims to achieve allows the staff on the units to relax and understand that this program is an add on to help patients, not take away from the hard work they already put in."

Facilitators of role and service model clarity described by projects included:

- Taking time to develop the service model and clarify roles of project staff, partners, and collaborators in early project development and design stages
- Developing a document "describing processes for referral, referral criteria and expectations for various roles"
- Organizing resources and information to be accessed at a single point of referral
- Having a shared vision
- Carrying out service planning with communities
- Ensuring project staff working in community are "a member of the community health team"

"Their shared vision of working together is one of the biggest accomplishments of the first year"

Technology and/or client record management

The availability and interoperability of an electronic medical record and/or policies and procedures for handling paper-based client records was a major tool for coordinated care that several projects mentioned.

Of the 20 projects that submitted reports, 65% (13/20) reported using one or more health information systems. A total of 15 different health information systems were described. An additional three projects mentioned that they were in the process of obtaining an EMR and three projects mentioned the desire to gain access. The most commonly reported systems were Mustimuhw, Meditech, and PARIS.

It is not solely the presence of an EMR that facilitated coordinated care, it is the ability for that system to communicate with other external systems such as physician's office scheduling systems, lab systems and MSP. Projects described challenges with alignment and compatibility among the different information systems being used within and across teams, facilities, and organizations as a barrier to collaborative and integrated care. In some cases, service providers within as a care team were using different information management systems.

Greater integration, compatibility, and communication between information systems would support client follow-up and continuity of care; communication and collaboration within and between care teams and sites; and reduction of inefficiencies and redundancies in administrative processes. One project highlighted their transition to using the same EMR as other local primary care clinics as an opportunity to "look at trends and patterns across the Aboriginal population on and off-reserve in [the region]".

> "We work with [regional health authority] to use their EMR, Profile with our doctors and MOA's. This allows the MOA's to connect with other clinics in the area to provide the best service for our clients."

> "Lack of access to Meditech and no eMR system-we used eMR funds to build our confidential server, video security and webinar software for confidential distance appointments."

> "The contracted NP is also on paper charts and doesn't have the same EMR as physician and [regional health authority] NP."

> "Alignment of our charting systems and an open transparency between all teams within the health care centre would remove some of the miscommunication or missed communications. [...] because of our separate systems, we don't often understand who is already assisting a client, and how we can leverage that support and connection."

> "There are, at this point, no systems that work across Public Health, various physician and midwifery offices, [regional health authority], communities and First Nations Health Authority."

This is a complex area that the JPB annual report template does not explore in detail, however more detailed information may be helpful to elicit from projects, particularly for those projects that have identified EMR issues as a problem.

Even in the absence of a stand-alone or integrated health information systems, patient charting policies and procedures for paper-based client records were an important component of coordinated care that projects worked to address. Some projects developed excel sheets or Sharepoint sites to store client records. Others developed paper-based charting policies and procedures that work for their service delivery model.

“[Regional health authority] worked with us to sort out charting by NPs to the Nation’s records (and not taking our client information back to [regional health authority] clinics)”

Processes and procedures: practice management, referral pathways

When creating a new health team there are numerous internal processes and procedures that need to be developed to support the work of the team. The JPB annual report did not collect any systematic information on the types of processes and procedures developed but a few projects mentioned the development of policies and procedures as a task that was important to the functioning of the team and that took time and collaboration to develop.

Examples of policies, procedures, and protocols to support practice management and operations that projects described developing included:

- Nursing chart and electronic client file libraries
- Resource binders for project staff
- Workload indicator documentation
- Billing / non-billing policies
- Procurement and supply protocols
- Criteria for client discharge from programs

“specific primary care clinic policies and procedures had to be developed […]. All of these challenges were met by [team/program leads] without any additional internal clinic management capacity, to undertake on top of their already busy workloads.”

In addition to internal operating matters, external integration of a new team into an existing health system requires numerous points of interaction and requires a level of specialized knowledge of the primary care system that some projects expressed the desire to have had more information about at the beginning of their project.

“no processes have been developed to allow the project Clinician to refer into or link clients with [health authority] resources.”

“In hindsight they wished there was a ‘primary care 101’ session which described all the moving pieces and especially the need to connect in to the very complex provincial e-health systems once you transition to electronic medical records.”

Management, coordination and admin support

Several projects mentioned the need for dedicated and ongoing management and administrative support for their programs. This included projects operating clinic-based and distributed models. Examples given of specific processes and program operations that are strained under present capacity include: managing bookings, coordinating roster of permanent and visiting practitioners, and to managing logistics associated with visiting health professionals such as negotiating agreements.

> "Practice Management is a huge gap for each Nation. This was not simply establishing a clinic and a handful of FTEs in each Nation. Becoming part of the 'primary care' system has created far greater capacity needs than Health Directors can sustain.... As a result there is now essentially a new 'team' within each of the Health Departments but no management capacity to manage these teams."

> "The only way we have able to meet our management support is only through the partnership contribution through [regional health authority] and our great relationship with Aboriginal Service Team."

Other projects mentioned their dependency on partners to provide management support or on internal staff that have other job commitments.

Projects spoke about the opportunities to increase the level and variety of care available by having such supports available. For example, one project described how the potential for greater involvement and integration of clinicians is partly limited by constraints on resources to manage the logistics of this.

Space, financial resources, human resources

Having space, building a network of partners, and having staff are essential building blocks for a project and these can be built upon to increase collaboration and coordination over time. Projects mentioned these initial resources as the spark that could lead to more and/or better service delivery.

Projects also mentioned that having more staff would enable opportunities and time for additional relationship building and collaboration with communities, clients, and other care teams.

> "We have begun hosting specialists [...] to conduct their consults here at the Health Centre. We have yet to analyze how this welcoming of external providers is going, but it seems clear so far that clients appreciate the co-location of specialist care, and the linking of their care to our team."

Projects have described working with other health service organizations, health authorities, and communities to leverage and combine available human resources, capacity, and facility space. In some cases, sharing of spaces and co-location of providers that might otherwise be working in separate practices has been an opportunity for greater collaboration and integration of care and services.

Communication and relationship development

Communication and the importance of developing relationships are themes explored in detail in section 9 below; however, several projects mentioned the importance of communication and relationships for system integration purposes explicitly.

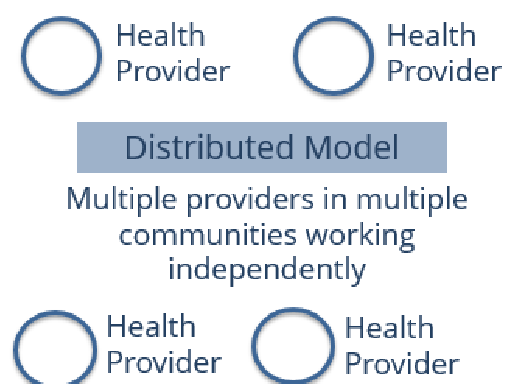
> "We also continually work on establishing working relationships with service providers who might be interested in coming to our communities."

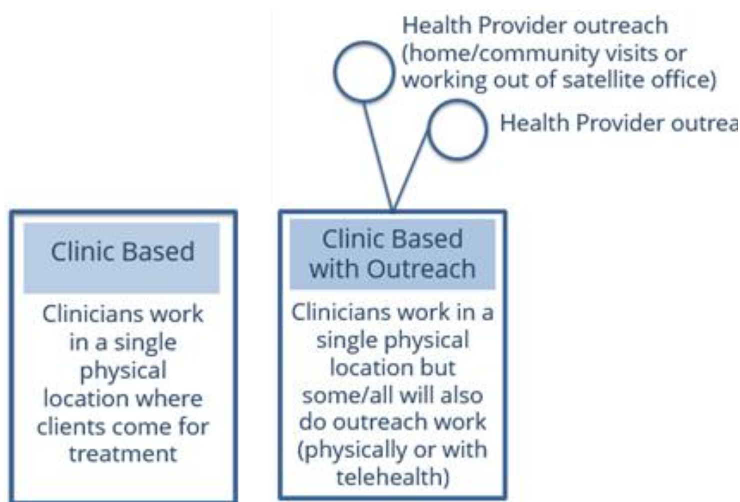
Section 8: Client-centred care delivery models

Many projects have described how their service models have been optimized for client-centred care delivery, to accommodate the needs of clients and communities and to improve accessibility of services.

Projects varied the way in which they delivered services. To facilitate comparisons of the numerous operational variances between projects, project service models implemented have been grouped into a few broad categories.

The spread of projects across service delivery models was quite even, with a slightly higher number of projects employing a **distributed model**, in which multiple providers work in multiple locations in a fairly independent manner (26% of projects). This model has the benefit of increasing the geographical coverage of services available. In some projects, geographically separate service locations were divided among different clinicians of the same profession to reduce travel burden. In others, different health care professionals would travel separately to each geographical location, requiring more travel. In the case of the latter, having a place to stay overnight while in-community was sometimes reported as a challenge.



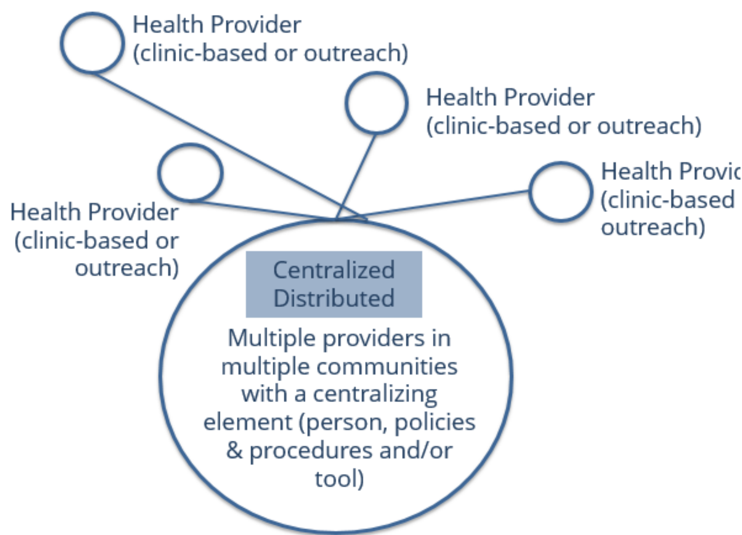


Next were the **clinic-based models**, either with outreach services (reported by 15% of projects) or without outreach services (reported by 11% of projects). If there was any mention of home visits, outreach visits in community, delivering care in satellite offices or virtual follow-up through telehealth the project was classified as 'clinic-based with outreach'. These projects focused on delivering care out of a single physical location, all were focused on primary care and all were based in First Nation communities. Five out of the seven projects that were clinic-based also delivered services to non-Aboriginal clients.

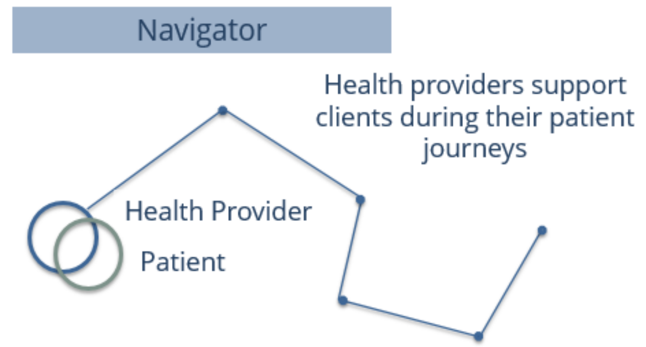
These models have configured new spaces or built upon existing clinical spaces to augment the amount or variety of services available in First Nation communities. Being housed within community was a key part of the success mentioned by these projects.

> "Much of the success of the project can be contributed to being hosted by a Nation rather than a health authority, as well as being community-based"

A **centralized distributed model** was reported by 11% of projects. These projects were similar to the distributed model in that their team members were made up of clinicians working in different locations, but differ in that there is a centralizing element, a staff person or a common set of tools or processes that support the team in integrating and coordinating care.

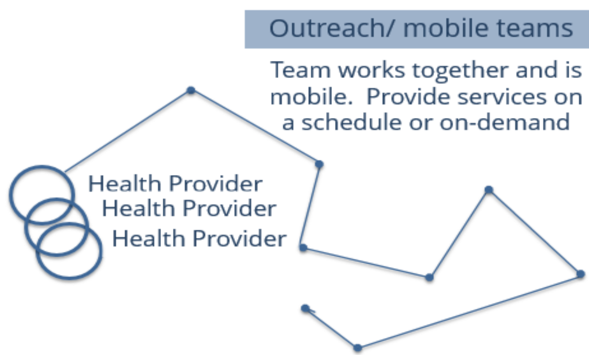


Also seen were **navigator** models, which had various clinical focus areas and accounted for 11% of projects. Navigators, with roles in care pathway coordination and navigation; case management; client advocacy, support and resource referral; have been instrumental in improving coordination and continuity of care; smoothing transitions between services and after discharge; bridging service gaps and fragmentation; and building a "circle of care" for clients. Three projects are classified as being navigator models.



"The [navigator] [...] began this process and has helped create a team to network and work collaboratively to provide seamless health care."

Two projects were **outreach/mobile teams** that focused on bringing teams of professionals to individuals and communities, either on an ad-hoc basis or on a set schedule. Both of these projects focused on mental health and substance use.



Projects that include outreach/mobile teams or elements of distributed models have enabled greater flexibility in service delivery. This flexibility has positioned projects and service providers to be responsive to client and community needs through delivering services in client- and community-defined locations that are accessible in terms of geographic location, appropriateness, and 'safety'. This has contributed to reducing accessibility barriers and supporting continuity of care by making it easier for clients to access and return to the same provider and point of care.

"The model of care is outreach to locations that FN communities have indicated are appropriate and accessible by members of their community."

A further 22% of projects were deemed to include **a mixture of the above-described models** (some clinicians in the team appear to be distributed, other clinicians seemed to be providing navigation services) or information was not available to be able to classify the project service delivery model.

Social Determinants of Health

Many projects described the linkages between their clinical services and broader social determinants of health. Some projects had positions that were specifically addressing these types of issues.

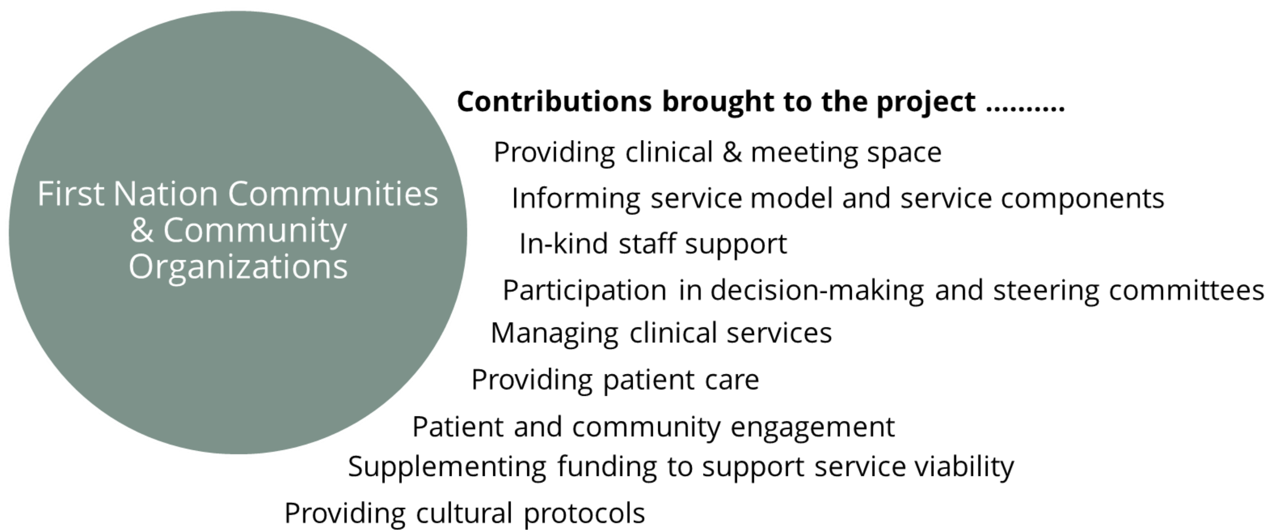
> "The [social determinants of health position] works closely with the doctors to ensure clients needs are met. This allows the doctors to spend more time with patients on medical needs knowing that other health needs are being met by the [First Nations Health Service Organization] Health team and outside service providers through the Service Navigator."

Section 9: Partnerships & collaboration

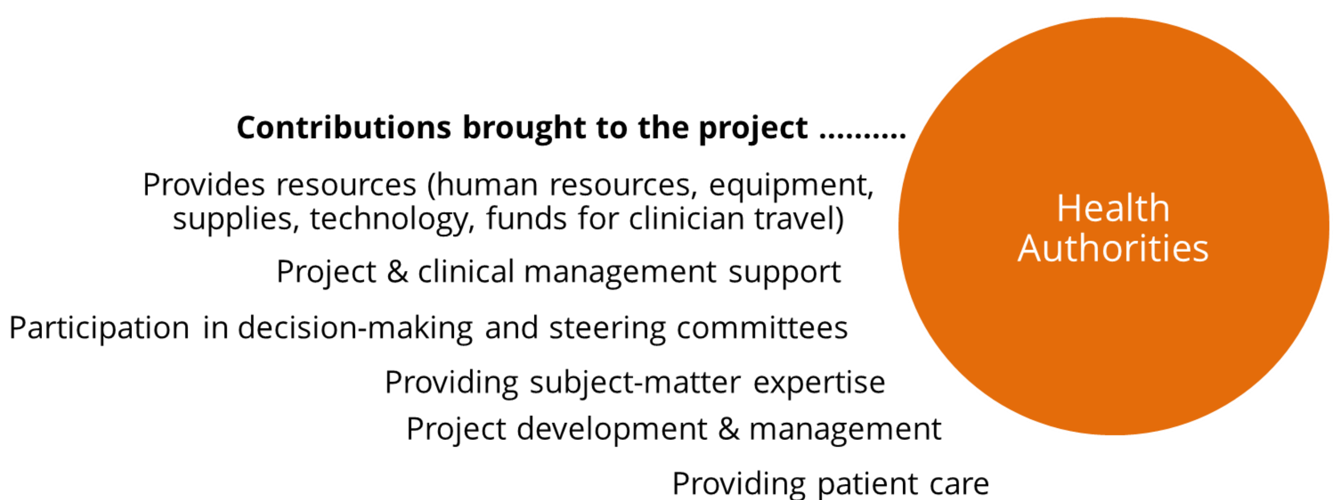
All projects reported working in partnership with different partner types, most frequently with First Nations communities & community organizations (e.g. community health departments, Health Service Organizations, tribal councils, friendship centres), local Health Authorities, non-health partners (e.g. housing providers, child & family services, schools, academics, libraries, police), clinicians & clinical services (e.g. Divisions of Family Practice, individual clinicians) and the FNHA.

The vast majority of partnerships were rated as being 'very good' or 'good', with only a couple partnerships rated as poor across all project reports.

9.1 How have projects been working with partners?



Rating of partnership........... 88% of reports rated their partnerships with First Nation Communities & Community Organizations as 'very good' or 'good'



Rating of partnership........... 90% of reports rated their partnerships with Health Authorities as 'very good' or 'good'

The supports provided by Health Authorities were diverse and included funds for clinician compensation (salaries, benefits, alternative payments for physicians); funds for supplies, equipment, protection services, technology; project development and management and; funds to support clinician travel.

Non-Health Partners include child & family services, school districts, housing providers, corrections and researchers.

Contributions brought to the projects ....

Providing practical supports and referrals (housing, education, transportation)
Wider circle of care collaboration, communication and networking
Grants from industry for capital renovations

Rating of partnership........... 87.5% of reports rated their partnerships with Non-Health Partners as 'very good' or 'good'

The majority of non-health partners (86%) were reported by projects in the Interior.

Contributions brought to the projects ....

Providing patient care
Participation in decision-making and steering committees
Providing subject-matter expertise
Providing clinical oversight
Providing referrals
Praising and acknowledging the work of partners
Communicating with provider community

Rating of partnership........... 100% of reports rated their partnerships with Clinicians and Clinical Services as 'very good' or 'good'

Reported contributions brought to the projects ....

Project development and management
Coordinate, advocate and provide project structure
Partner

Rating of partnership........... 90% of reports rated their partnerships with the FNHA as 'very good' or 'good'

The lowest rating of FNHA was in Vancouver Coastal.

Several projects mentioned leveraging other FNHA funding streams to support the success of their project including Block funding, capital funding, Health Actions, Regional envelopes, Hope, Health & Healing funding and traditional wellness funds.

9.2 Facilitators to effective collaboration, communication and governance

The annual report asked projects to describe their partners and the factors that contributed to a successful collaboration with each partner. Across all partnership types many of the factors reported to have contributed to a successful partnership were similar. These included:

Capitalizing on existing relationships & investing time to maintain or build stronger relationships

Regardless of the type of partner, building relationships, meeting regularly and communication were mentioned as contributing factors to successful partnerships.

Several projects mentioned the use of existing governance bodies and structures to build upon relationships and address issues or concerns as they arose or even addressing non-JPB issues through these structures**.**

One project spoke to the evolution of their relationship and communication styles with partners over time.

"Interestingly service issues outside of the JPB projects are being discussed and solutioned at the PAC tables between partners as a natural evolution of the partnerships."

"The JPB has provided a bridge between FNHA, [regional health authority] and partner community agencies and has allowed for better transparency of service delivery and a better understanding of the challenges faced by the partnering agencies."

Partners being flexible, adaptable and committed

Flexibility, creativity and support from Health Authorities, Clinicians and non-health partners during the development of the team, during active incidents or during time-sensitive events was mentioned by several projects as contributing to successful partnerships.

Motivated partners that are desirous to work together towards a common goal was also mentioned by projects as contributing to the success of their partnerships. Projects spoke of the partnerships between communities and the sharing of resources: one community gave their telehealth equipment to another community; another shared their clinical policies and procedures.

Leadership and support from executive and front-line staff

The support of executive, front-line staff, or both was mentioned as a facilitator to collaboration, particularly for project partnerships with their local Health Authority or the FNHA.

Staff whose role or activities bridge several organizations or provides patient navigation

Several projects mentioned that having a team member that held positions in both their team and another partnering organization, or having their team member embedded within another

"The housing of the position of [...] in the Aboriginal health Team has brought a cohesive and fluid approach to person centered care to the position and helped to foster linkages between Aboriginal Health, Acute Care Services and the community nursing teams."

partner team was helpful for collaboration. This benefit was also explored briefly in the section 2.1 ‘Fragmentation of services’.

There were projects however that mentioned that having individuals with multiple employers in the same team was a challenge when it came to prioritization of work and discipline/termination of a shared service provider.

9.3 Barriers to effective collaboration, communication and governance

The annual report also asked projects to describe their partners and the barriers to successful collaboration with each partner. Encouragingly, across all partnership types many projects reported that they faced no barriers to partnership. The issues raised fall in the following themes:

Lack of trust, support, communication or engagement, including historical relationship issues

Some projects indicated that some project partners were not fully engaged in the work or that historical relationship issues hamper current collaborative efforts. Other projects mentioned the need for clear communication between teams.

> “[Local] physicians and Division of Family Practice (DPF) do not yet acknowledge the [First Nation community/people] and [Nation] Territory in an appropriate way. They also do not acknowledge the work of [Nation] Health Leadership.”
>
> “Many different players involved without clear communication between teams”

Suggestions for facilitating better relationships with partners included:

- Meeting more regularly, nurturing relationships further and increasing communication
- Using existing advisory bodies/governance structures to address issues or concerns
- Higher-level leadership discussions to facilitate better relationships particularly with Health Authority and non-Health partners
- Working to develop or update agreements to facilitate partnerships with Health Authorities (TOR, LOU)

Operational integration issues (scheduling, referrals, case management, access and storage of client records, multiple EMRs, multiple employer teams, a lack of or incongruent policies and procedures)

These types of operational issues are explored more fully in section 7; however, inadequate access to these important operational tools and resources was also mentioned as a barrier to effective collaboration and partnership.

Geographical remoteness or distance

Geographical distance between partners can be a barrier to collaboration. One project mentioned that teleconferences were the best option for collaborative work over large geographical areas, but found that the lack of face-to-face meetings was not as effective for moving their work forward.

Section 10: Program sustainability

The main topics related to the sustainability for projects relate to financial sustainability, administrative and clinical supports, client load and provider burnout.

Financial sustainability

Particularly for the clinic and clinic outreach models, a concern expressed was the need to supplement project funding by billing fee-for-service for non-status clients. This however has repercussions for additional administrative support to coordinate and manage this work.

> "A positive input toward sustainability will be the potential for the clinics to start billing especially for non-Status patients so there is ability for the clinics to bring in revenue to help with their costs."

Management and Admin support

Several projects mentioned the need for full-time administrative support as well as the need for ongoing practice management. This concept is also explored in more detail in section 7.

> "[Nation] could not operate a clinic with a .2FTE Medical Assistant. They had to have an MOA there every day to support patients coming in .. and to ensure requests from the Doctor were carried out and followed up (e.g. lab tests) and to be available for patients ringing in to make appointments."

Client load and complexity of patient needs

Several projects mentioned the fact that clinicians cannot see new patients because they have reached a ceiling in terms of their patient load. Other projects identified the need to develop policies and procedures to help define when a client is no longer on the client caseload. Some projects have rolled out the implementation of their initiative in stages so as to "refine processes and manage expectations".

> "Once the [team] gets fully up and running, we anticipate challenges in meeting the service demand and managing expectations. The [team] is a small team and the patient/family needs are significant."

Provider burnout

Related to the concept of overcapacity is the concept of provider burnout, another important sustainability theme expressed by projects, which is discussed more in section 4.1.

Measuring long-term outcomes

One project mentioned the constrained ability to report on long-term outcomes achieved as a barrier to sustainability. The vast array of different project service models and the relatively light evaluation requirements for all 27 JPB projects makes capturing longer-term outcome data particularly challenging.